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MoHealthNet Oversight

Directors Update
Tuesday, November 5, 2019

Vision Statement

*Together we will build a **best in class** Medicaid program that addresses the needs of **Missouri's most vulnerable** in a way that is **financially sustainable**.*

Why Transformation?

"Transformation is the process of fundamentally changing the systems, processes, and technology across a whole **business** or **business** unit, to achieve measurable improvements in efficiency, effectiveness and stakeholder satisfaction."

- Current system is unsustainable
- Health outcomes are not acceptable
- Payment Models are outdated and not aligned with State's goals
- Very few incentives to increase quality and almost no incentives to control costs
- Good work is being done in some areas – but these basic problems are not isolated

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Acute Care Services

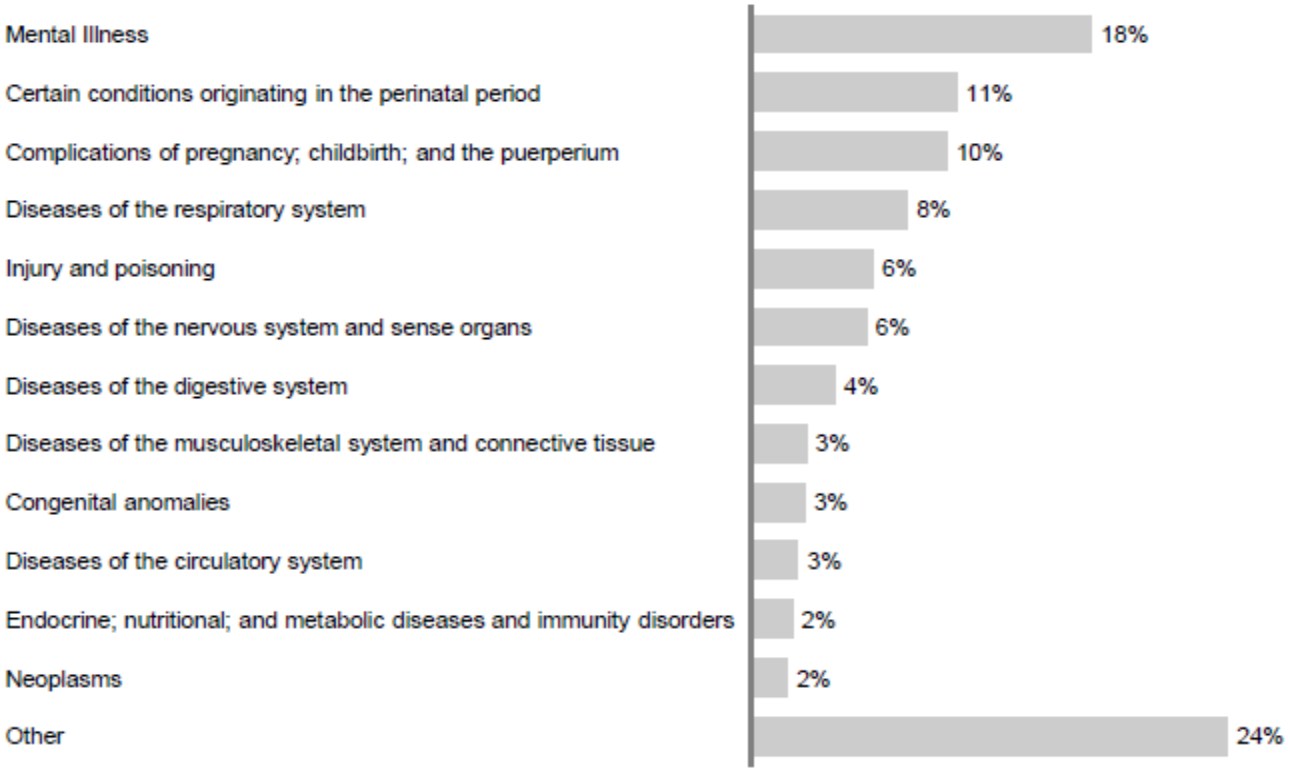
Medical Costs by Diagnosis Group for Managed Care Population

SFY2018

MANAGED CARE POPULATION

Medical spend by diagnosis groups for adult and child claimants, SFY2018

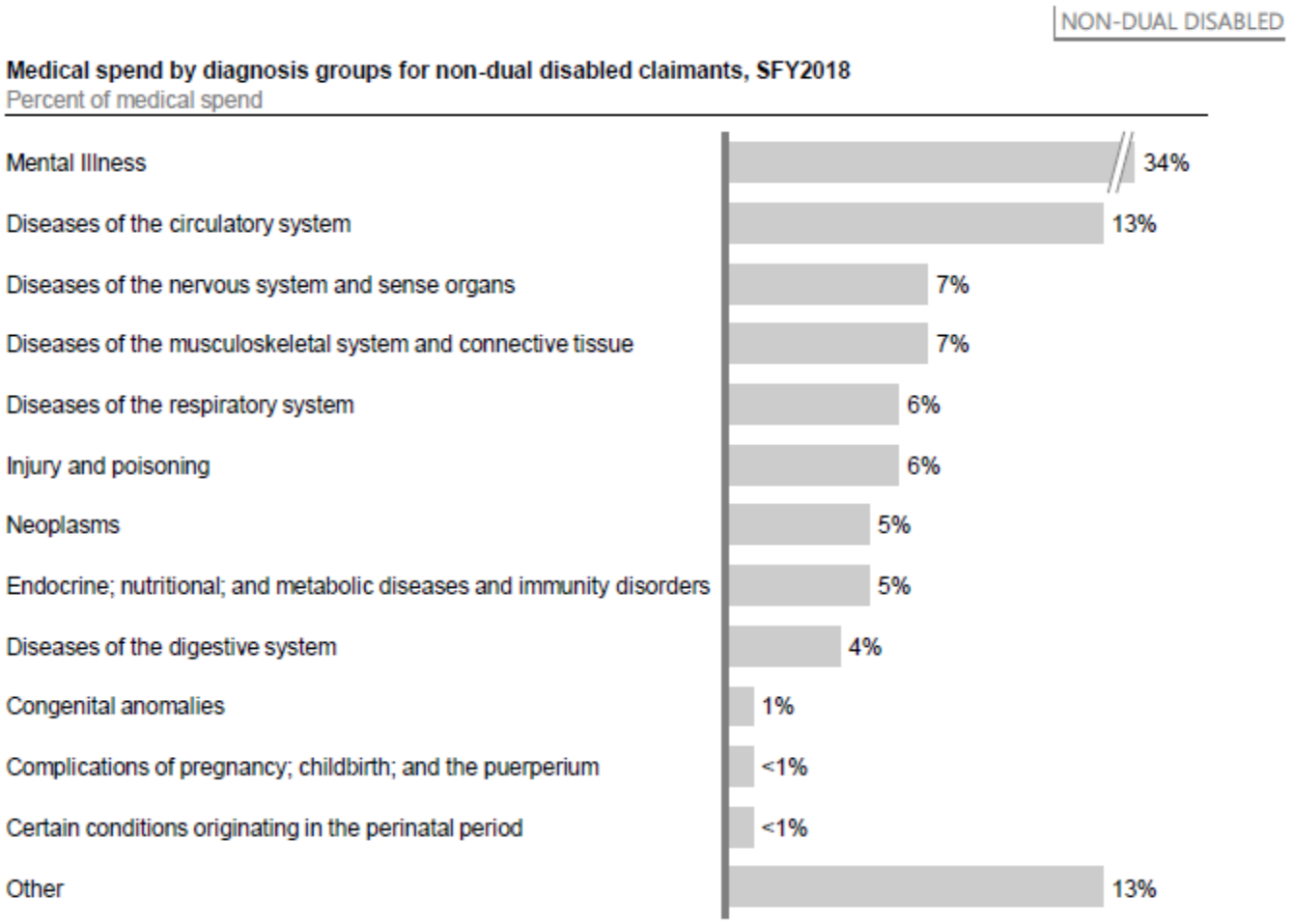
Percent of medical spend



Source: Rapid Response Review –
Assessment of Missouri Medicaid Program Final Report

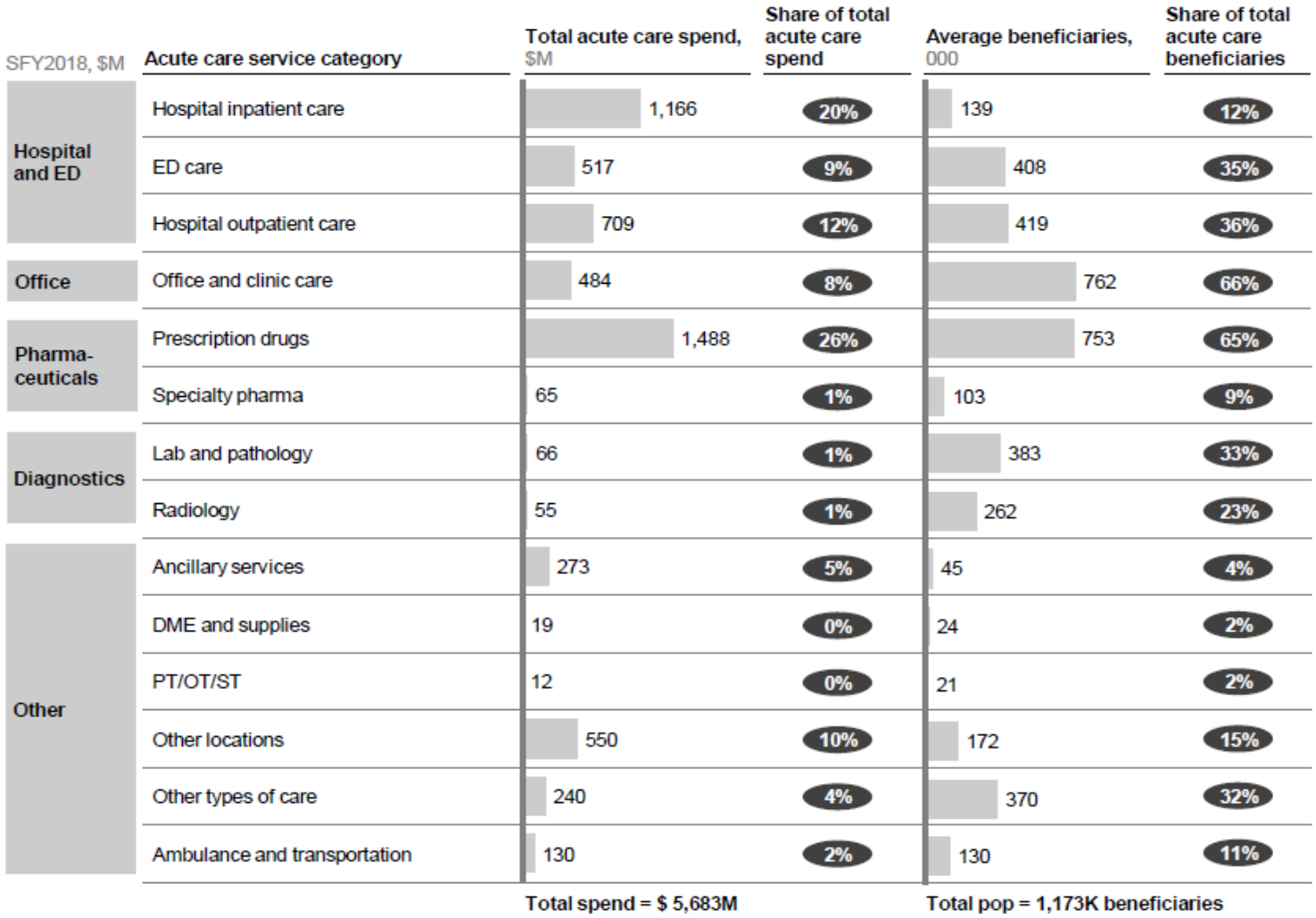
Medical Costs by Diagnosis Group for Non-Dual Disabled Population

SFY2018



Source: Rapid Response Review –
Assessment of Missouri Medicaid Program Final Report

Acute Care Costs by Service Category

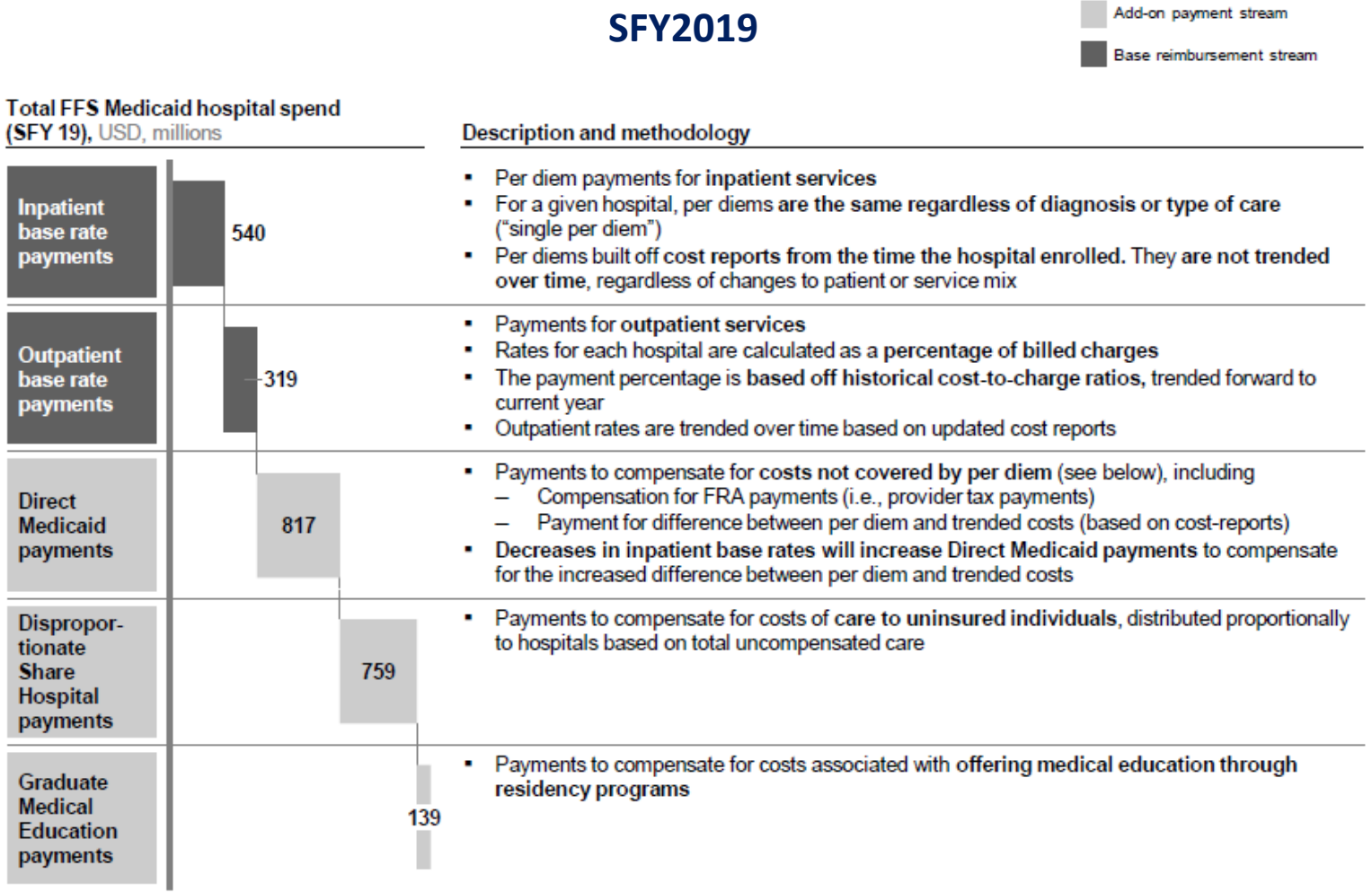


SFY2018, $M	Acute care service category	Total acute care spend, $M	Share of total acute care spend	Average beneficiaries, 000	Share of total acute care beneficiaries
Hospital and ED	Hospital inpatient care	1,166	20%	139	12%
	ED care	517	9%	408	35%
	Hospital outpatient care	709	12%	419	36%
Office	Office and clinic care	484	8%	762	66%
Pharma-ceuticals	Prescription drugs	1,488	26%	753	65%
	Specialty pharma	65	1%	103	9%
Diagnostics	Lab and pathology	66	1%	383	33%
	Radiology	55	1%	262	23%
Other	Ancillary services	273	5%	45	4%
	DME and supplies	19	0%	24	2%
	PT/OT/ST	12	0%	21	2%
	Other locations	550	10%	172	15%
	Other types of care	240	4%	370	32%
	Ambulance and transportation	130	2%	130	11%
		Total spend = $ 5,683M		Total pop = 1,173K beneficiaries	

Source: Rapid Response Review – Assessment of Missouri Medicaid Program Final Report

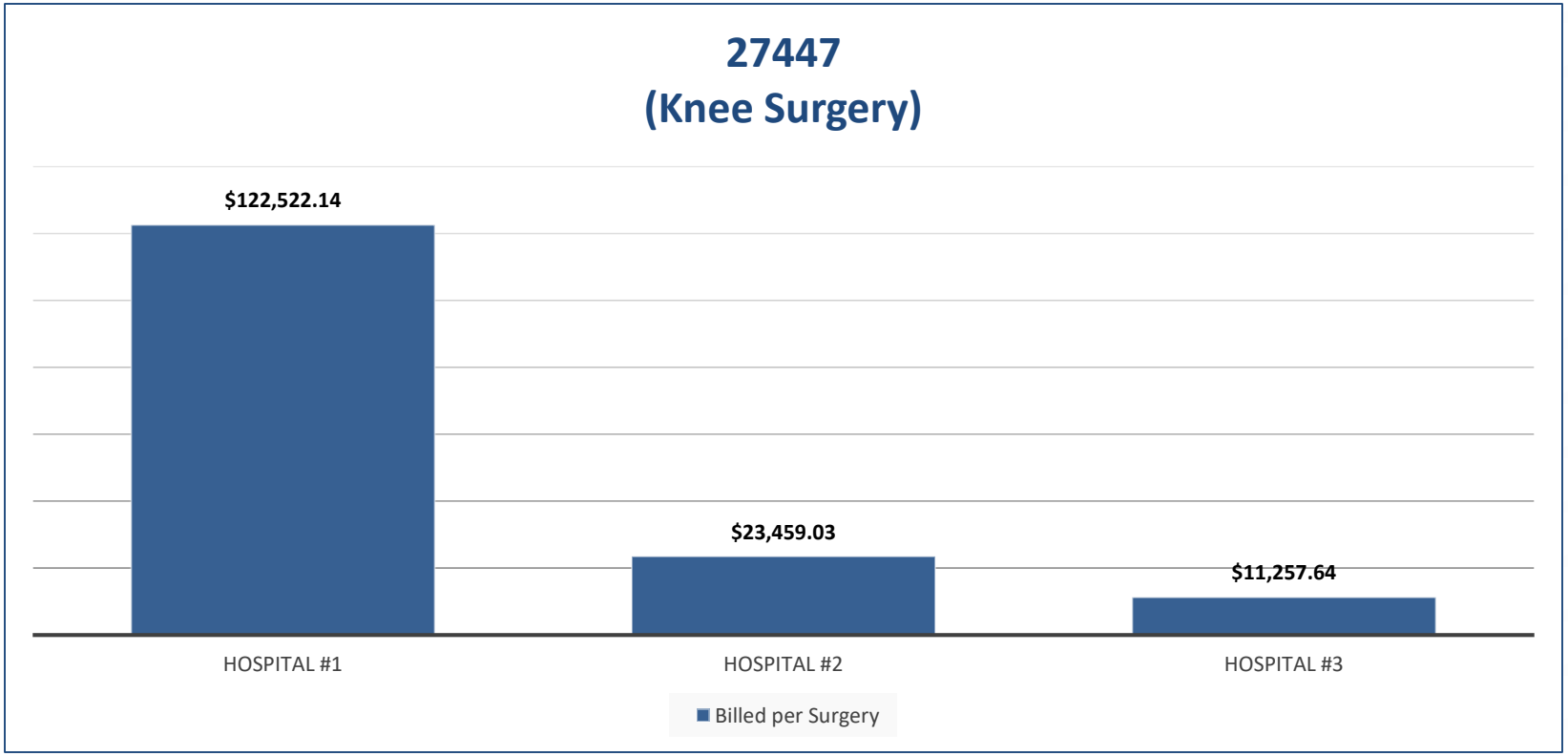
Hospital Reimbursement: Medicaid FFS

SFY2019

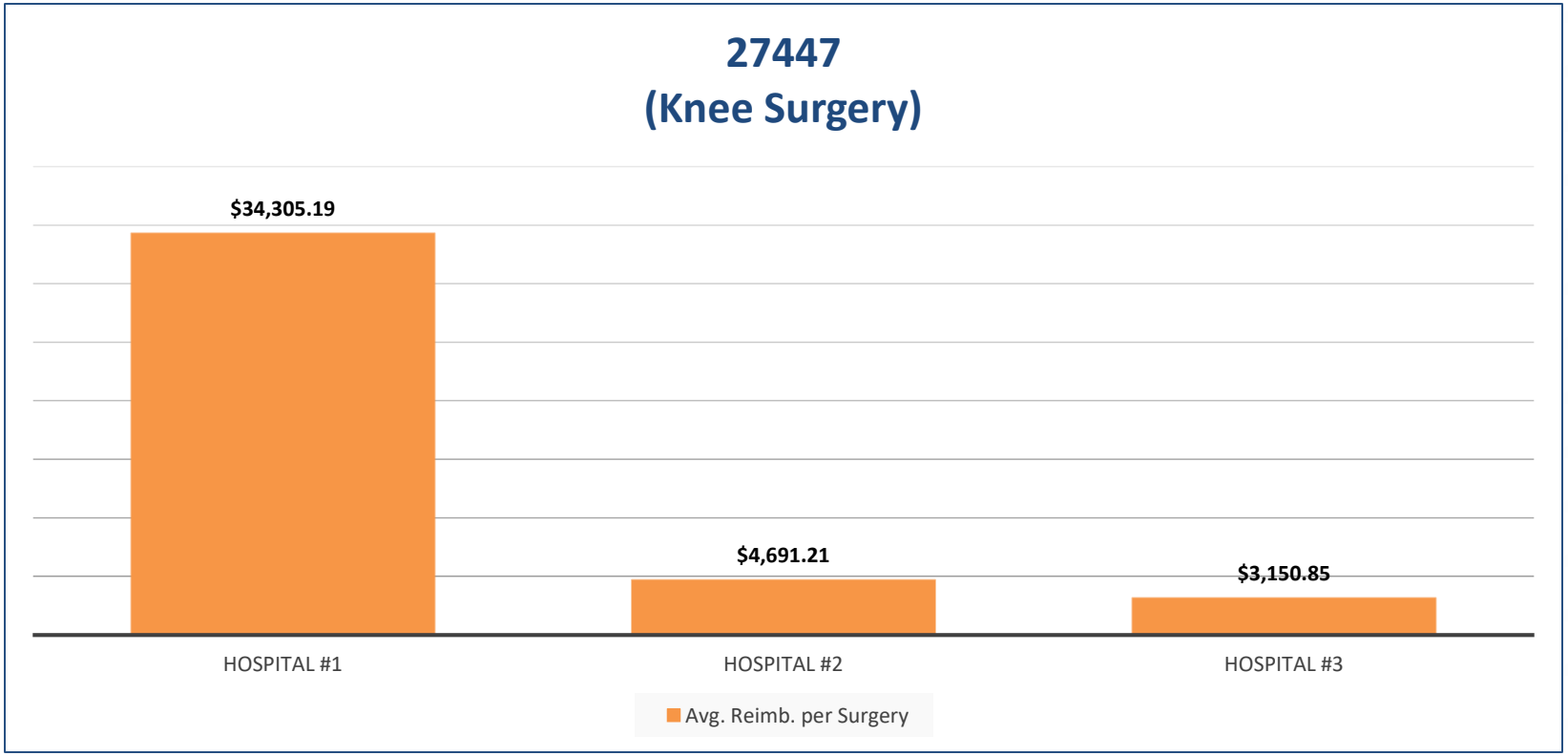


Source: Rapid Response Review – Assessment of Missouri Medicaid Program Final Report

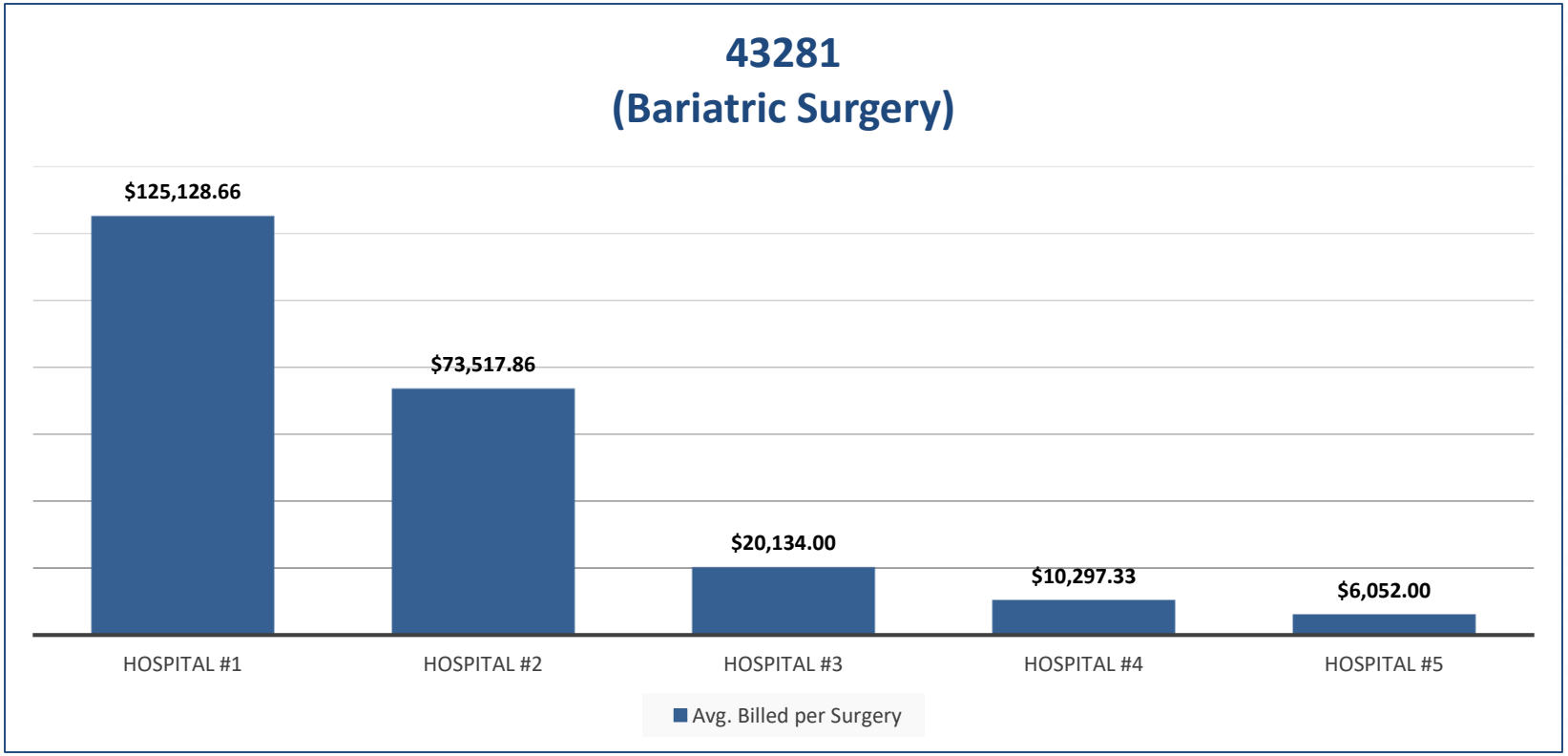
Average Billed



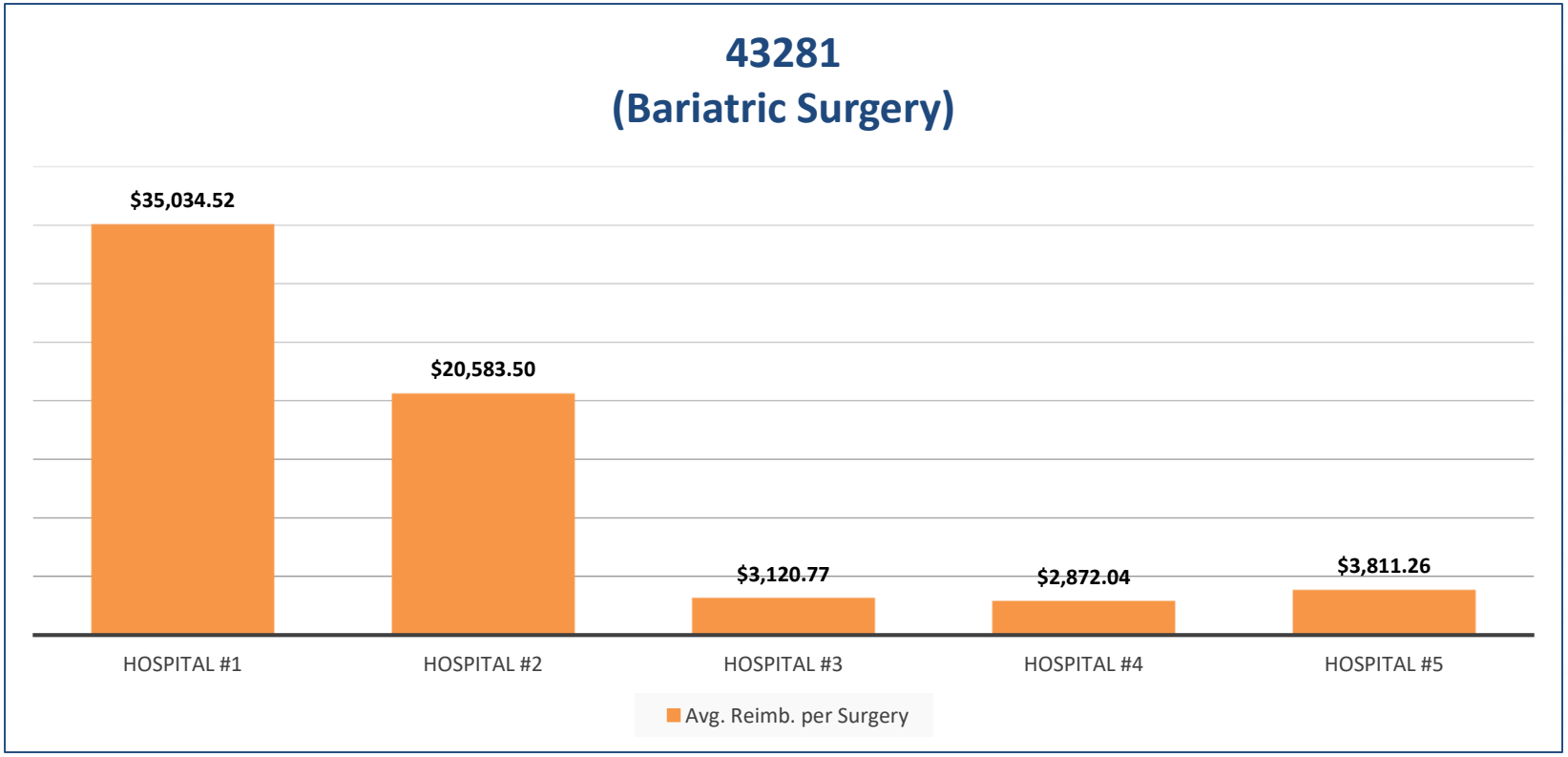
Average Reimbursed



Average Billed



Average Reimbursed



Physician Reimbursement

Physicians are paid based on a fee schedule that is historically linked to Medicare but is not regularly updated.

Reimbursement rates are less in Missouri than in other states:

- Missouri Medicaid pays 79% of the national average physician services (ranked 46th);
- For primary care, the state pays 81% (ranked 42th).

Reimbursement for non-hospital physician services, including Federally Qualified Health Centers (FQHCs), clinics, and rural health services, Missouri is lower than other comparable states:

- In SFY2016, Missouri spent 5% of total expenses on non-hospital physician services, as opposed to 9% in comparable states.

Source: Rapid Response Review –
Assessment of Missouri Medicaid Program Final Report

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Where We Are Going…

Acute Care Services

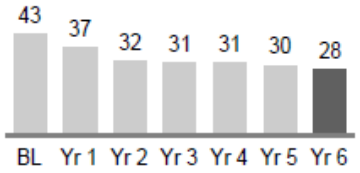
- Shift outpatient hospital reimbursement to fee schedule.*
- Review prior authorization for outpatient procedures.*
- Reduce/Repurpose out of state direct Medicaid payments; modify direct Medicaid payments methodology; re-examine payment levels for financially vulnerable rural and safety net providers.
- Adjust MCO hospital payments.
- Improve physician and behavioral health reimbursement.
- Transition to value-based payments. This may include VBP for acute care, multi-payer VBP alignment, adjusting readmission policies, creating transparency of outcomes, and may include managed care

Impact of Primary Care Health Homes: Hospital Use

SFY2012-2018

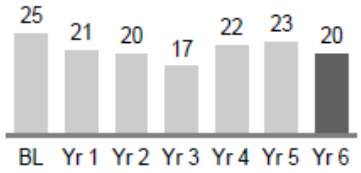
Utilization results across all PCHH enrollees

Percentage of PCHH enrollees who had an ED visit, %



There has been a 35% decrease in ED use for all PCHH enrollees from baseline, through year 6 of the PCHH program

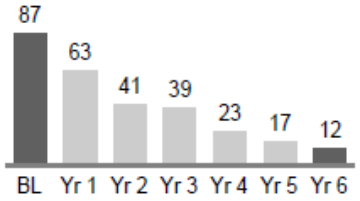
Percentage of PCHH enrolees who had a hospitalization, %



There has been a 20% decrease in hospital use from the baseline, through year six of the program.

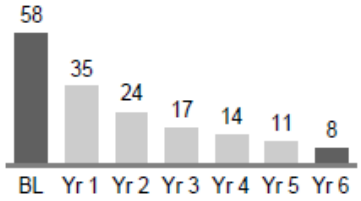
Utilization results across high utilizers

% of high utilizers with ED visits



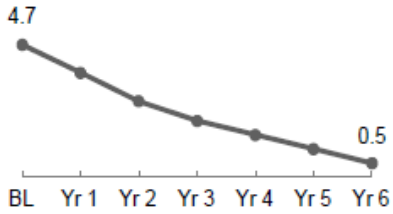
There has been an 86% decrease in ED visits for individuals who are considered to have high ED or hospital utilization.

% of high utilizers with hospital admissions



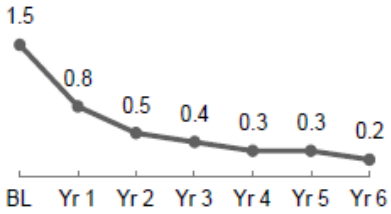
In total, the percentage of high utilizers who are admitted to the hospital has been reduced by 86%.

Average # of ED visits for high utilizers



The average number of ED visits decreased from 4.7 visits per person to less than one visit/person by year six, an 89% decrease.

Average # of hospitalizations for high utilizers

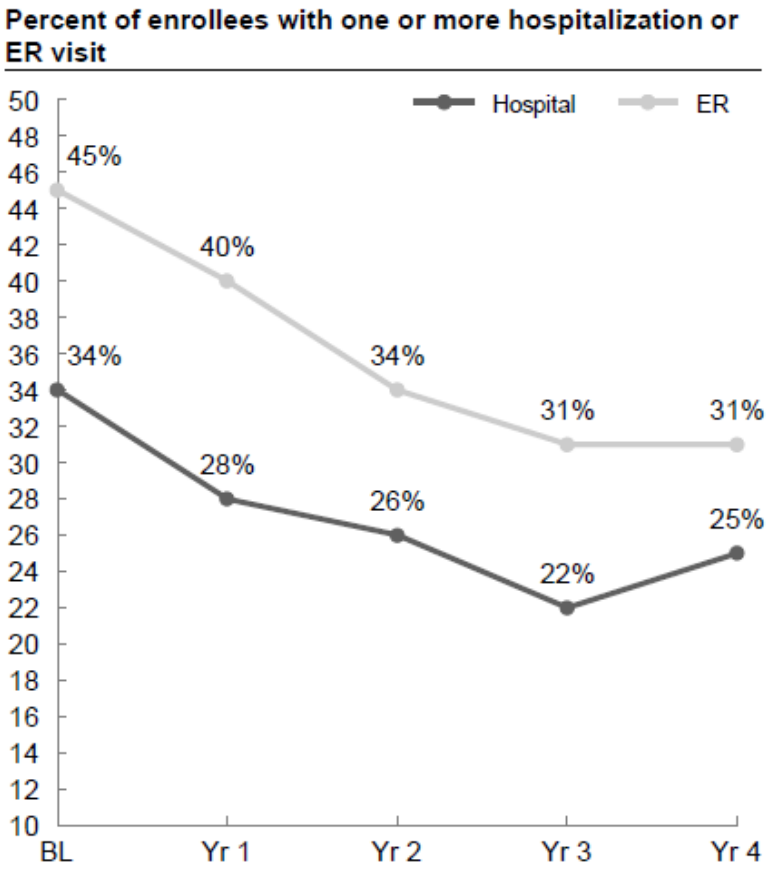


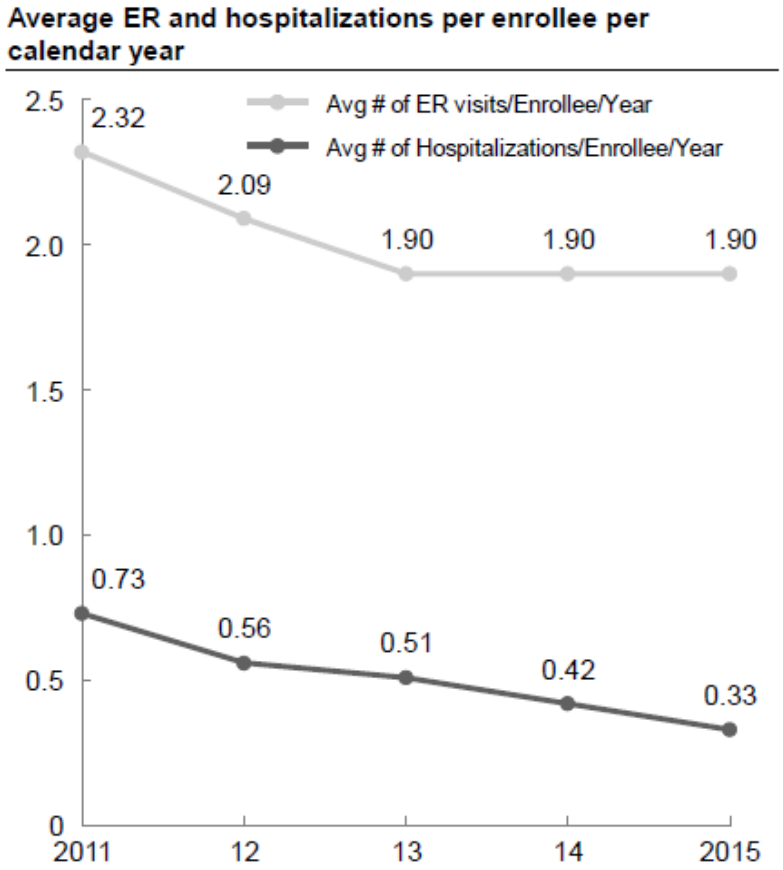
The average number of hospitalizations has decreased by 87 % from baseline to year six.

The impact of PCHH on ED and hospital use has been especially effective among high utilizers

Source: Rapid Response Review – Assessment of Missouri Medicaid Program Final Report

Impact of Community Mental Health Center Health Homes: Hospital Use SFY2011-2015





Average number of hospitalizations has been reduced 14%, and average emergency room visits decreased 19%

Source: Rapid Response Review – Assessment of Missouri Medicaid Program Final Report

Achieving Success

- Bring Medicaid spending growth in line with growth in Missouri's economy
- Ensure access to services that meet the needs of our participants in every part of Missouri
- Improve participants' experience and healthcare outcomes, and increase their independence.
- Partner with providers to modernize our care delivery system
- **Become a leader in the implementation of value-based care in Medicaid**

Near Term/High Impact Initiatives Implemented or "In-Flight"

- Acute Care
  - Shift top 50 outpatient surgeries to a fee schedule*****
  - Shift remainder of outpatient hospital reimbursement to fee schedule
  - Alternatives to Chronic Pain Management
- Program Integrity
  - Fraud, Waste and Abuse Taskforce *
  - Expand capability to identify additional improper payments that can be prevented using claims edits and pre-pay changes or can result in recoveries*
  - Improved collaboration and communication between MHD and MMAC*****
  - Improve Third Party Liability identification
- Pharmacy
  - Reduce grandfathering and maximize rebate capture
  - Require NDC on non-j codes*
  - Better tools to Monitor RX and eliminate over utilization
  - Increased Prior Authorizations and Claims Edits on Opioids and Benzodiazepines (Xanax)*
- Managed Care
  - Incorporate additional efficiency measures into the managed care rate-setting process*
  - Quality-based withholds – to increase accountability and provider collaboration
- Long Term Services and Supports
  - DHSS Assessment Changes
  - DMH – CMHC and Value Based Payments
  - Extend Money Follows The Person
  - Pace - program of all- inclusive care for the elderly
- MMIS/Systems
  - Enterprise Data Warehouse
  - Management Dashboards – Increasing transparency and evaluation of outcomes
- Operations
  - Enrollment Broker
  - Removing Unnecessary or duplicative processes
  - Benefits Determination Processes

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